Advising the Congress on Medicare issues

A critical evaluation of the Medicare hospice benefit

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Presentation roadmap

- Brief background on hospice benefit
- Updates on financial analyses: Medicare margins and hospices exceeding the cap
- Policy areas
  - Payment system reform
  - Accountability
  - Data needs

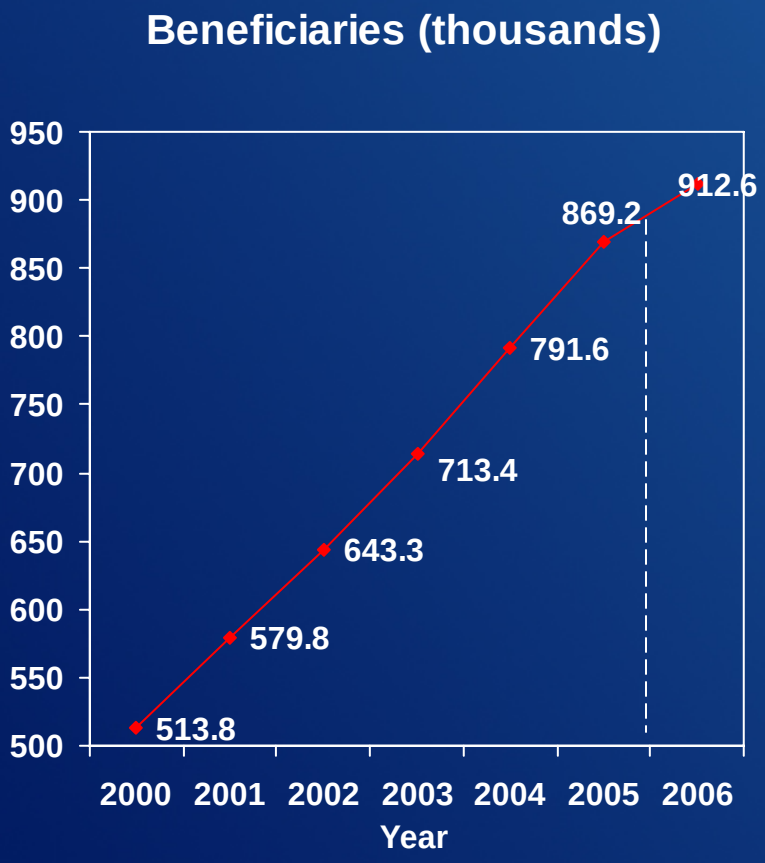
Medicare's hospice benefit – key points

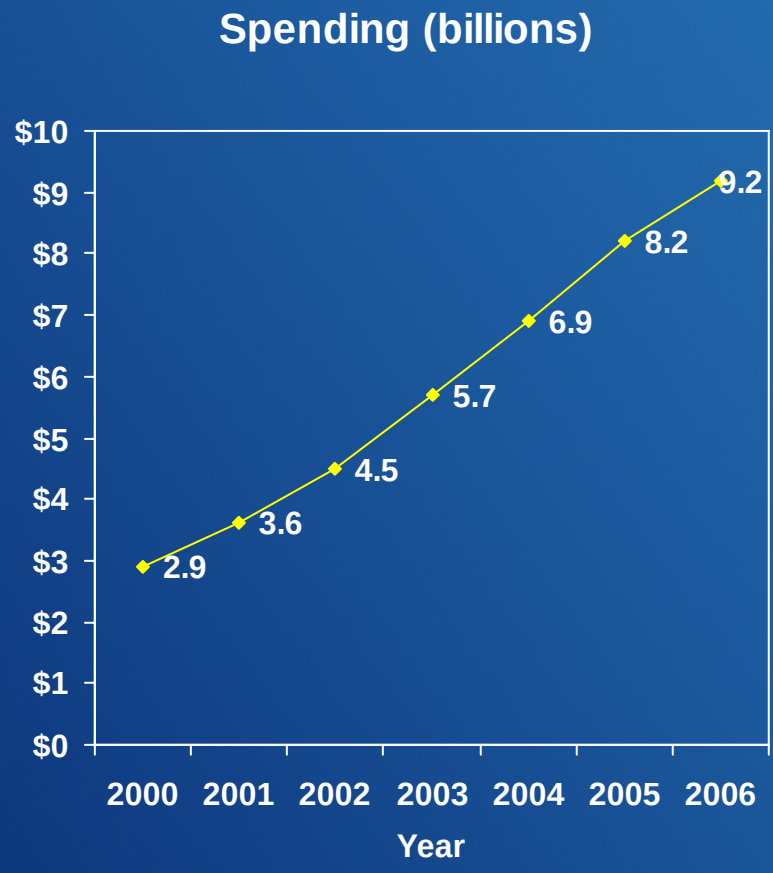
- Two tenets:
  - Provides beneficiaries with an alternative to intensive end-of-life curative treatment
  - Benefit implemented on presumption that it would be less costly to Medicare than conventional end-of-life treatment
- Medicare payment system embodies incentives that may undermine second assumption

Areas for further investigation identified last year

- Payment system reform
- Accountability
- Need for more information

Hospice utilization and spending grew rapidly between 2000 - 2006





Source: Centers for Medicare and Medicaid Services.
Note: 2006 utilization data is calendar year, all others are fiscal year.

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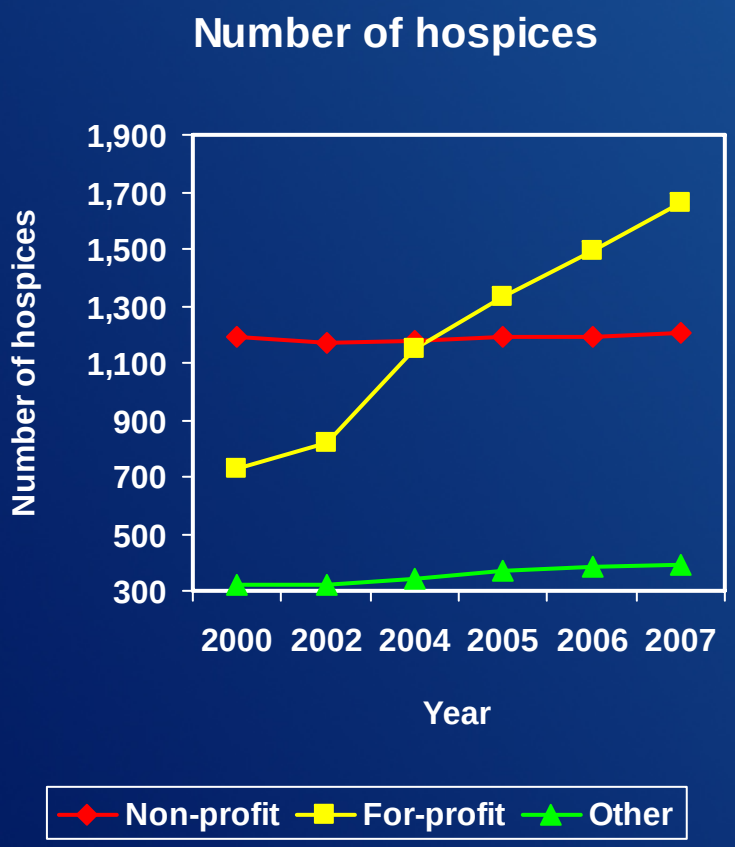
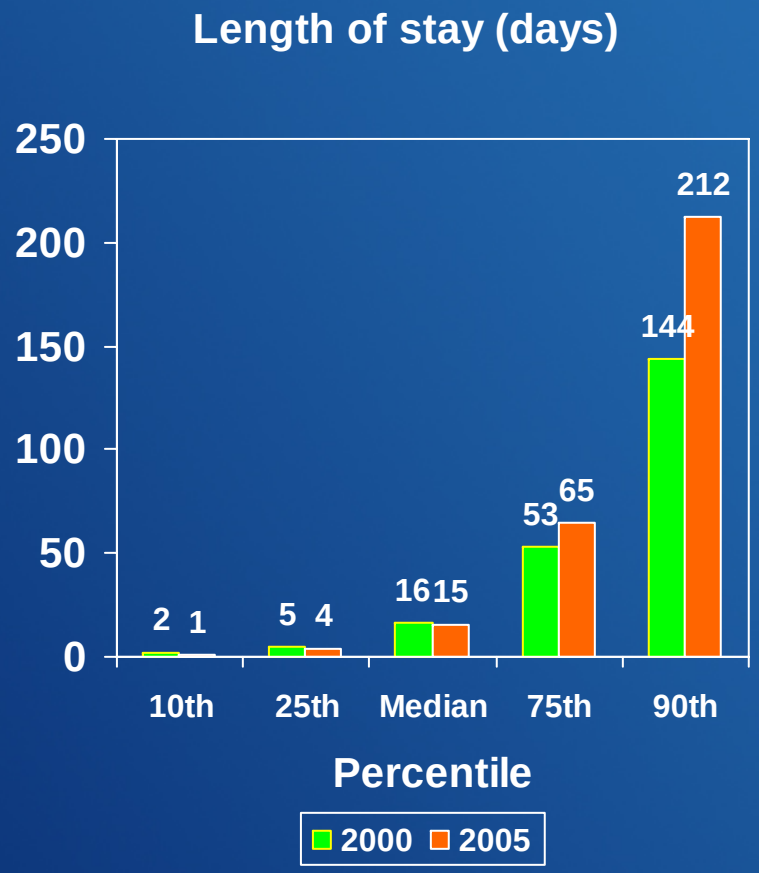
Numbers of hospices, and length of stay, also grew in recent years





Source: Medicare claims and provider-of-services data from the Centers for Medicare and Medicaid Services.

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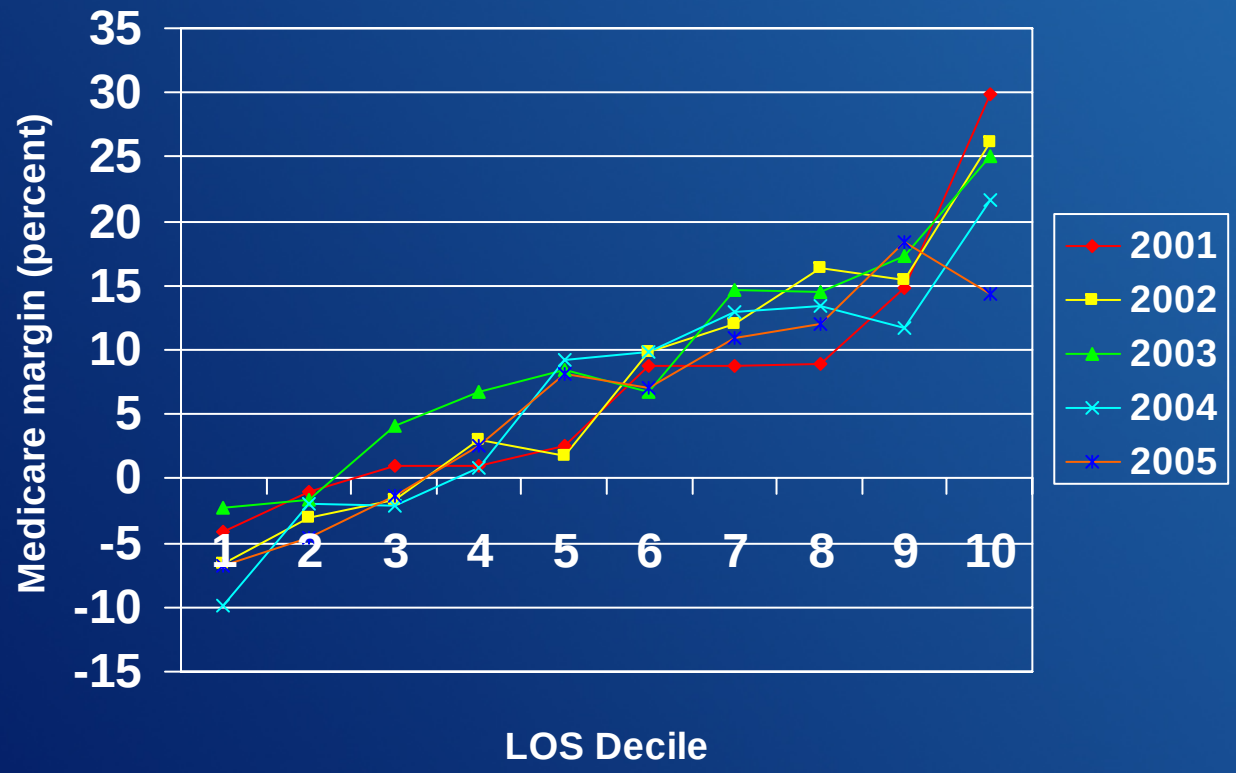
Hospice margins increase with longer length of stay



Source: MedPAC analysis of 2001 - 2005 100% hospice claims standard analytical files (SAF) and Medicare hospice cost reports from CMS.

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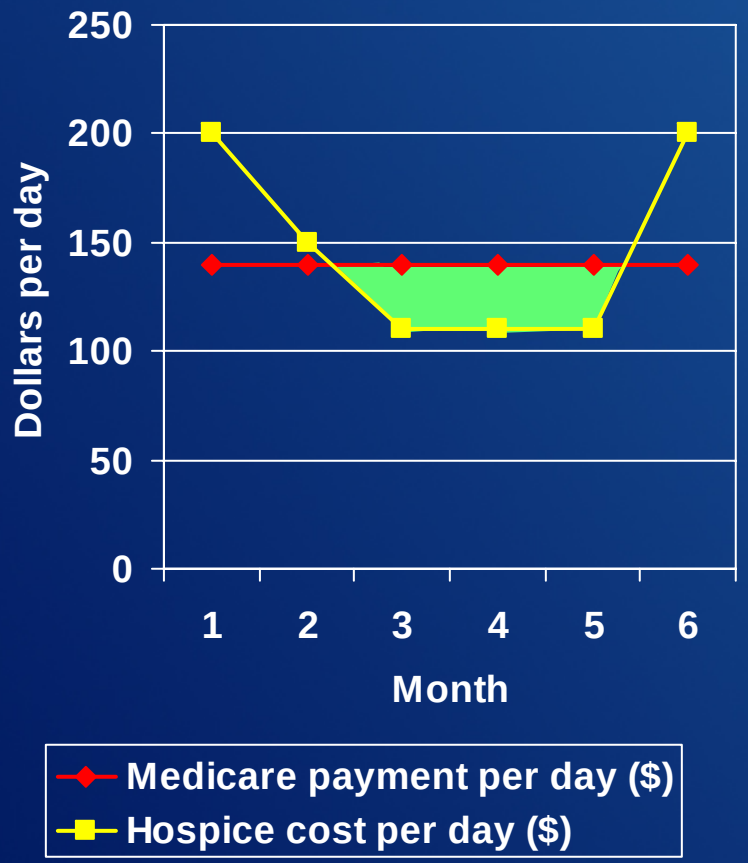
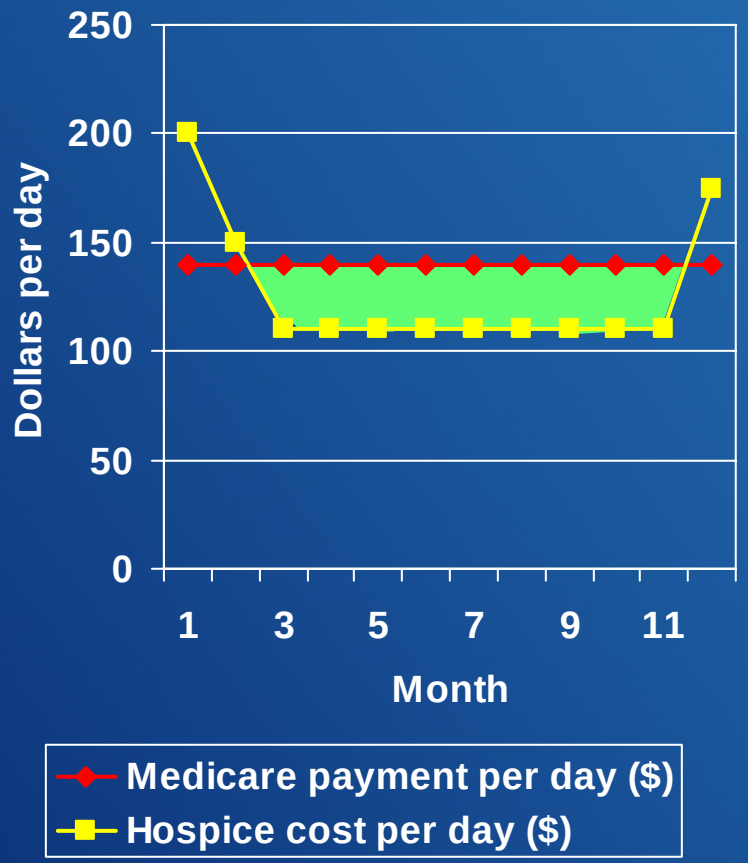
Illustration of incentives for long hospice stays under current payment system





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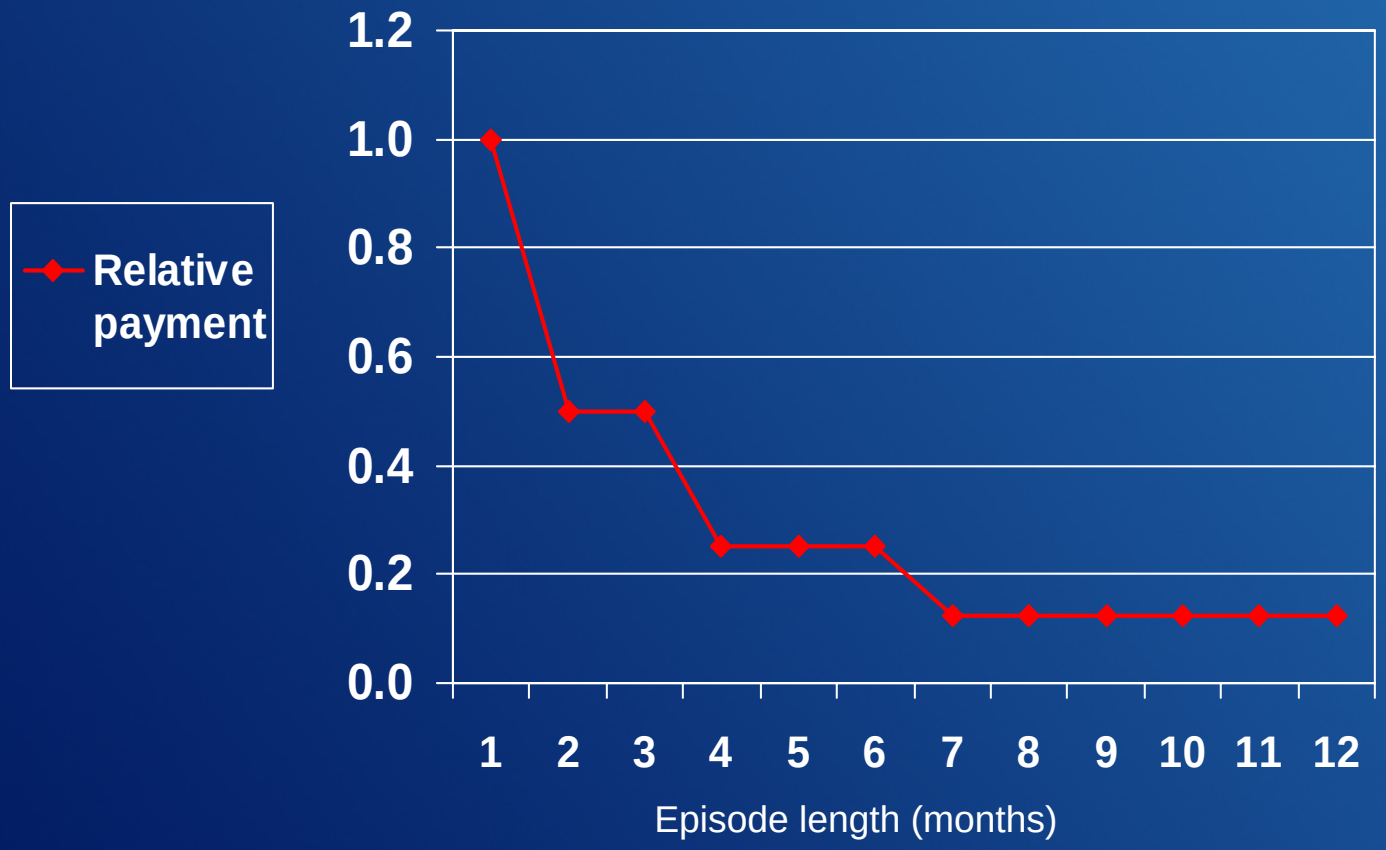
Level of payments should decline as length of stay increases

- Payment system should better reflect hospices' cost curve
- Payments should decline over the course of an episode
- A "decedent payment adjustment" could be made after the patient's death
- Structure would create incentive for hospices to more carefully screen patients for admission

Model of stepped-down component of revised payment system



Note: model portrayed on slide does not reflect decedent adjustment.

Preliminary (partial) impacts of this approach

- Would redistribute payments in a budget neutral manner as a function of average length of stay (ALOS). Payments to hospices with long ALOS would be reduced; payments to hospices with short ALOS would increase.
- As secondary effect, would change payments for different types of hospices:
  - For-profits: -3 percent
  - Free-standing: -3 percent
  - Non-profit: 2 percent
  - Provider-based: 11 percent
  - Rural: 5 percent

Benefits of this approach

- Consistent with program goals (providing appropriate hospice care at the end of life)
- More closely parallels hospices' cost function, but maintains pressure for appropriate length of stay
  - Makes hospices more sensitive to long-stay patients
  - Reduces unprofitability of short-stay patients

Accountability

- Long-stay patients
- Hospice admissions from nursing facilities

Long-stay patients

- The length of long hospice stays has been increasing
- Top ten percent of patients had a length of stay of:
  - at least 144 days in 2000
  - at least 212 days in 2005

Current hospice eligibility process

- Certification and Recertification
  - Initially, two physicians must certify terminal prognosis
  - Recertifications require signature of hospice physician only
  - Recertification at 90 days, 180 days (6 months), and every 60 days thereafter
- Medicare Local Coverage Determinations (LCDs)
  - Guidelines for determining if prognosis is terminal
  - If LCD criteria not met, beneficiary may be eligible for hospice if physician certifies terminal prognosis based on clinical factors not addressed by LCD.

Expert panel perceptions concerning compliance with eligibility criteria

- Many hospices comply with Medicare eligibility criteria
- But some hospices enroll and recertify patients that are not eligible
- Reasons for variation in compliance
  - Level of physician engagement
  - Inadequate charting
  - Lack of physician or staff training
  - Financial incentives / questionable eligibility

More accountability and oversight needed for long stay patients

- Consensus emerged among panel about need for more accountability and oversight
- Panelist suggestions
  - Physician/APN visit for recertifications at 180 days and every 120 days thereafter
  - Require all certifications include a brief explanation of clinical basis for prognosis
  - Greater enforcement of LCDs targeted toward providers with very long lengths of stay
- Additional issues related to nursing home patients

Financial incentives for referral and admission of nursing facility patients to hospice

Nursing facility incentives:

- Cost savings from splitting provision of patient care with hospice
- Possible additional payments to the nursing facility for provision of certain services on behalf of the hospice

Hospice provider incentives:

- Cost savings from seeing multiple patients at one location and from splitting provision of care with nursing facility
- For dually eligible beneficiaries, Medicaid room and board payments pass through hospice provider to nursing facility
- Nursing facility may be a source of patients that have longer stays and require fewer visits per week.

Medical directors of nursing facilities influence hospice referrals and are central to potential conflicts of interest

- Medical directors of nursing facilities
  - Act as primary care physician for institutionalized beneficiaries
  - Certify terminal health status and refer to hospice provider
- Potential for conflict of interest may exist where:
  - Nursing facility and hospice provider have joint ownership
  - Hospice provider compensates the medical director of nursing facility for referrals

Data needs - claims

- Have historically contained minimal information (days of each type of care)
- 2008 – CMS implements new requirement
  - Collects information for some (but not all) hospice staff who provide visits
- May be benefit to collecting additional information
  - Information on *all* visit providers
  - Information on duration of visit

Data needs – cost reports

- Cost reports
  - Data quality issues – not used to adjudicate payments
  - Content issues – differentially does not include critical content
    - Payments
    - Visits
    - Uniform reporting of days of care
    - Other revenues

Conclusions

- Given incentives,
  - payment system changes needed
  - Additional accountability controls also needed
  - Additional data needed, but some (e.g., cost report changes) may take time to implement